CHAPTER 1
INTRODUCTION

1.1 History of the Newborn Intensive Care Program (NICP)

Prior to 1967, Arizona had one of the highest infant mortality rates in the country. That year, in an effort to reduce the high infant mortality and morbidity rates, Arizona applied for and received a federal demonstration grant. The grant was designed to reduce infant death by transporting critically ill newborns born in rural hospitals into intensive care centers. As a result, there was a dramatic decrease in neonatal mortality. Part of that grant was to provide home based Community Nursing Services to the infants and their families. Community Health Nurses provided follow-up home visits for the NICP infants and their families up to one year of age.

In 1972, the State Legislature provided state funding for the program, which eventually became the Newborn Intensive Care Program (NICP). The system provided care to those infants transported to metropolitan hospitals (Level III's) and expanded to include infants born in Level II or Level III hospitals. Comprehensive and periodic developmental assessments were an additional component of the follow-up services provided in specific areas of the state.

In 1975, Arizona Department of Health Services (ADHS) received a Robert Wood Johnson Grant to develop regionalized perinatal care with a focus on the maternal transport system. Under this grant, the Maternal Transport Program (MTP), the Arizona Perinatal Program (APP), the Arizona Medical Association (AMA) and the University of Arizona began to develop guidelines for Level I, II, and III perinatal hospital services, a perinatal data system and the system of maternal transport.

In 1977, it was demonstrated that babies did very well if transported to hospitals closer to their homes following the acute phase of their illness. Therefore, back transport was added as a component of the NICP.

In the late 1980's ADHS Office of Women's and Children's Health (OWCH) with the county health departments identified a need for home-based community health nursing services for those infants who may not have been critically ill at birth but were diagnosed with problems at a later date.

Part C of the Public Law for Individuals with Disabilities Education Act (IDEA), provided incentive for the development of a system of early intervention services

which could provide a comprehensive, culturally appropriate, multi-disciplinary, family centered approach to all families. In 1993, ADHS awarded contracts to developmental clinics to determine eligibility for the Arizona Early Intervention Program.

In 2002, funding for the developmental clinic component was eliminated. Arizona physicians and therapists then had few options for the evaluation of their developmentally delayed patients. Physicians began working closely with the Arizona legislature to restore funding for this much needed service. In FY 2005, the legislature partially restored funding to allow the HRPP/NICP to provide developmental assessments to program enrollees who do not meet Arizona Early Intervention (AzEIP) eligibility criteria and are uninsured or underinsured.

The Community Health Nursing component works with families to improve their infant's developmental outcomes. Services may be provided through a child's third birthday.

Research has demonstrated that the health of the mother before she becomes pregnant plays a significant role in the wellbeing of the newborn. To address those issues the CHN also incorporates Post Partum wellness assessment and guidance about intraconception wellness into her/his family centered care.

During FY 2009, the state experienced a severe budget downfall. As the result of budget reductions, and in an effort to serve the sickest infants, the Program changed eligibility to infants who have spent at least 5 days in the NICU and restricted back transports to families who live over 50 miles from the NICU. The Developmental Services component was eliminated at that time also as a result of underutilization.

1.2 Description of the Program (See flow sheet at end of chapter)

The NICP is the major part of the High Risk Perinatal Program. The transition of the program name to High Risk Perinatal Program (HRPP) is due to the fact that the program provides a statewide system of specialized care for high risk pregnant women and sick newborns. There are currently three program components to the HRPP/NICP.

- Transport Services
- Hospital Inpatient Physician Services
- Community Nursing Services

1.2.1 Transport Services

Medical Consultation and Case Management Services

ADHS contracts with neonatology and perinatology groups in the state to provide medical consultation regarding the treatment, stabilization and, if needed, coordination of neonatal and maternal transport. This service is provided free of charge to all callers.

Information and Referral Services

ADHS provides access to a toll free telephone service that provides the crucial link between referring health care providers and consulting perinatologists and neonatologists. If, at the time of consult, a transport is deemed necessary, the contracted neonatologist or perinatologist will make transport arrangements with a contracted transport company.

STATE WIDE TOLL FREE
INFORMATION AND REFERRAL NUMBER
1-800-552-5252

Transport Services

Families benefit from the Transport Program by having a coordinated system in place to ensure appropriate transport and admission to high risk perinatal centers. The services are initiated without prior authorization or verification of payment source to prevent delays in service delivery.

ADHS contracts with medical transport companies to provide air and ground transport, as well as team services, for high risk pregnant women and sick neonates. HRPP/NICP transport providers must obtain administrative specialty program direction from board certified perinatologist or neonatologist licensed and practicing in Arizona and authorized by the HRPP/NICP. HRPP/NICP transport providers must be accompanied by a program contracted transport team.

1.2.2 Hospital and Inpatient Physician Services

ADHS contracts with all Level II, II enhanced qualifications (EQ), and III perinatal centers (see glossary) that are certified by the APT/APRS, Inc., to provide the appropriate level of hospital care to Program babies and their families.

Contracts are in place with ADHS contracted physician groups to provide appropriate medical care to program infants during the newborn intensive, intermediate or continuing care hospitalization.

In addition, the Program contracts with all Level II EQ and Level III centers to support the implementation of developmental care practices in their newborn intensive care units.

1.2.3 Community Nursing Services

The Community Nursing Services component of the HRPP/NICP delivers a statewide, coordinated system of specialized nursing services to infants who are enrolled in the Program. The Community Health Nurse (CHN) provides support to families during the transition of the infant to home; conducts developmental, physical and environmental assessments, screens mother for post partum wellness and provides education about intraconception health. When appropriate, the CHN makes referrals to specific community services as needed. The CHN also will collaborate with the mothers on issues related to their own wellbeing in an effort to improve their ability to meet the needs of the enrolled infants and decrease the likelihood of a poor birth outcome with subsequent pregnancies. This program is linked with the Office for Children with Special Health Care Needs (OCSHCN) to provide services for families who do not meet the eligibility criteria for HRPP/NICP but could benefit from these services.

Currently the HRPP, CHN Services and the Office for Children with Special Health Care Needs (OCSHCN) have collaborated to support home visiting for other children with special health care needs to the age of twenty-one (21). The CHN's also collaborate with the Newborn Screening Program (NBS) to provide home visits for infants who need a second screening.

1.3 Financial Assistance/Benefits to Infant and Family

The HRPP/NICP Hospital Services Program provides limited financial assistance for families who request financial participation. The Program's role is **payer of last resort.**

1.2.1 Family Liability/Billing

Hospitals, using the ADHS formulas, establish the liability for each family requesting financial assistance. All contracted hospital and physicians agree not to bill the family more than their established family liability. Family liability is based on one amount per family rather than per child in the event of a multiple birth delivery. The liability is established once to cover all associated inpatient costs for the infant (s). The HRPP claims coordinator tracks the distribution of family liability payments and notifies each provider how much they can bill the family.

The family's liability is the total amount that the family must pay to contracted providers before a bill is considered for payment by HRPP/NICP. The family liability is generally applied to hospital and physician bills accordingly: 75% to hospitals and 25% to neonatologists. If the hospital does not require utilization of the full 75% the remaining liability will be assigned to physician or transport charges. Families are **not** protected from costs with providers who do not have a contract with ADHS.

1.3.2 Maternal Transports

Maternal transports by contracted providers are paid by HRPP/NICP after all other third-party payments. The HRPP Request for Maternal Transport Form must be completed and signed by the patient or responsible party and must include the name of the contracted perinatologist and name of Level II EQ or III perinatal center.

1.3.3 Neonatal Transports

Neonatal transports completed by contracted providers are paid once the HRPP/NICP enrollment is complete and after all other third-party reimbursements.

1.3.4 Neonatal Back Transports

Neonatal back transports by contracted providers are paid by the HRPP/NICP after all other third-party reimbursements if the transport is authorized by a contracted neonatologist. Payment for transport to a non-contracted hospital, Level I hospital or out-of-state hospital is provided only with prior authorization from the Transport Services Program Manager. Back transports will only be authorized when the family home is greater than 50 miles from the NICU where the infant is being treated and if the family is enrolled as full participation.

1.3.5 Non-Contracted Ground Transports

Non-contracted ground transport providers may participate in the Transport Program and may be reimbursed as payer of last resort. However, if they choose to participate, they must abide by the Transport Services Policy and Procedure Manual.

The HRPP/NICP does not pay for any services provided at non-contract facilities prior to the transport or for the mother's health care costs.

1.4 Mission Statement

The mission of the HRPP/NICP is to reduce maternal and infant mortality and morbidity through regionalized statewide system of coordinated care that includes consultation, transport, NICU hospital care and community health nursing.

1.5 Philosophy

The recipients of our services are families who live within broader systems that include extended family, friends, and communities. All services provided by this program are reflective of this philosophy.

A. Successful development and implementation of the HRPP/NICP depends on a partnership with families, members of the medical community, funding sources and policy makers.

B. Risk appropriate transport, hospital care and community home nursing services should be available and accessible to all critically ill newborns in Arizona regardless of geographic location and ability to pay.

C. Developmentally appropriate care is mandatory for the optimal development of the infant. This philosophy of care:
   1. is incorporated into discharge planning upon admission to the HRPP/NICP
   2. is based on the infant and family needs
   3. supports an environment conducive to maximum healing and growth

D. The family is the most important resource and decision maker in a child's life; therefore, they should be active participants in the hospital care, discharge planning and the ongoing interventions of their infants.

E. Primary care providers are crucial in the medical management of all infants, both at home and during necessary hospitalizations.

F. All children have intrinsic value and the right to maximize their potential for productive independence.

G. Follow-up after discharge is critical for:
   1. strengthening the family unit
   2. assuring optimal development of the child
   3. identifying physical, developmental, psycho-social and environmental issues that may lead to referral for early intervention services
   4. assisting families to be the best advocates for their child

H. Referral for needed services should include community-based options for families whenever possible.

I. A system should be in place to protect families from catastrophic costs that may be associated with newborn intensive care.

1.6 Goals and Objectives

1.6.1 Overall NICP Goals

The goal of the NICP program is to reduce maternal and infant mortality and morbidity utilizing the following strategies:

a. Early identification of women and children at high risk for mortality and morbidity;
b. Education for health professionals, families and communities;
c. Linkage of infants, toddlers and pregnant women to risk appropriate

services;
d. Establishment of standards of care.

1.6.2 Community Health Nursing Specific Goals

a. To encourage normal developmental patterns in high risk infants and toddlers.
b. To help children function better when they reach the school system.
c. To empower families to function at the highest level by assessing their own needs in accessing community resources.
d. To ensure the highest quality risk appropriate care for infants and toddlers at risk.
e. To provide family-centered, culturally sensitive, and developmentally appropriate, coordinated services.
f. To provide families of high risk children with developmental evaluations to determine eligibility for early intervention services and/or developmentally appropriate activities for their child.
g. To provide services in a setting that best meets the needs of the family and child.

1.6.3 Objectives

a. Support families who participate in evaluation, assessment, education and/or the community referral process of their child.
b. Develop a statewide developmental evaluation and monitoring system that is comprehensive and available to all infants, toddlers and preschoolers.
c. Standardize quality of services.
d. Plan and implement an evaluation system, which includes data collection.
e. Seek funding for continued program development.
f. Encourage the participation of parents and other community advisors in policy development, business meetings, and continuous quality improvement activities.

1.7 Overview of Roles and Responsibilities

ADHS is designated as the state agency responsible and accountable for program goals and expenditures. HRPP/NICP is administered by ADHS, Public Health Prevention Services, Bureau of Women's and Children's Health (BWCH),

Office of Children's Health. HRPP/NICP performs a variety of roles in the oversight of the Program: as a regulator, as a partner, monitor, facilitator, technical advisor, educator, and payer.

1.7.1 ADHS Roles and Responsibilities

a. ADHS and its contractors share a dynamic role in the development and evolution of the HRPP/NICP.

b. The HRPP/NICP collaborates with the APT/APRS, Inc., and AHCCCS for establishing standards of care and participation within the regionalized system.

c. ADHS provides the criteria, policies and requirements for developing and implementing the high quality, developmentally, risk appropriate transport, and intensive care services state wide for high-risk pregnant women and critically ill newborns. The philosophy reflects the core requirements of the HRPP/NICP Program, while also attempting to promote the family centered approach that is the cornerstone of the program.

d. ADHS contracts with perinatal centers (Levels II, II EQ, and III Hospitals) which may recruit and manage a unique group of specialized providers, such as neonatologists, perinatologists, pediatricians, nurses, paramedics, respiratory therapists, social workers, developmental interventionists, communication specialists and other ancillary personnel.

e. The ADHS Community Nursing Services program component contracts with local public and private agencies (contractors) that may recruit and manage a unique group of specialized providers, community health nurses, social workers, and early interventionists, (speech/language pathologists, physical and occupational therapists).

f. The ADHS contracts with air transport companies who meet established eligibility standards. These companies may recruit and manage a unique group of specialized providers such as perinatologists, neonatologists, specialty nurses; i.e., NICU, ER ICU or L&D, respiratory therapists, communication specialists and other ancillary personnel. In an effort to provide the most risk appropriate comprehensive care, the HRPP High Risk Transports may only be

performed by these contracted companies.

g. The HRPP/NICP is funded by State and Federal dollars.

1.7.2 Contractor Roles and Responsibilities

Services are contracted through providers statewide. Coordination among all service programs and rural specialists is essential for an efficient, statewide, family centered program. The contractor is expected to:

a. Provide services to:
   i. Infants and toddlers meeting NICP eligibility
   ii. Infants and toddlers and children meeting "Children with Special Health Care Needs" requirements
   iii. Mothers and families of NICP enrolled infants.

b. Provide individualized family-centered developmentally appropriate home visits in a setting and at a time which is most appropriate for meeting the needs of the child and family.

c. Recruit, hire and train professionals who meet minimum specifications as outlined in Chapter 4.

d. Provide written quarterly reports as outlined in Chapter 8.

e. Establish a linkage with referral sources for children and their families needing services within the Contractor's community.

f. Provide orientation, training, ongoing education, and support to the professional staff as outlined in Chapter 4.

g. Provide a Continuous Quality Improvement (CQI) plan for Community Nursing Services based on the ADHS/OWCH CQI policy. At least two components of the CQI will be determined by ADHS as outlined in chapter 8.

h. Collaborate and coordinate with parents, team members and other community providers in order to offer a family centered approach to care

i. Provide orientation and ongoing updates to staff on the requirements

of the Community Nursing Services Contract

Written notification will precede any changes in Contractor responsibilities. Contractors will be given a 30 day grace period before the change is expected to be implemented.

1.8 How To Use This Manual

The purpose of this manual is to document the HRPP/NICP Program's policies for management of the Program. The manual is to be used as a reference and information resource for community nursing contractors, ADHS administration and other interested parties in fulfilling the mission of the Program.

The policies contained herein are the minimum acceptable requirements to contract with ADHS to provide community nursing services to Arizona's maternal and neonatal population.

This manual will be reviewed at least annually and revised as necessary. Suggestions for changes to the manual to clarify a policy or to update a procedure may be sent in writing or fax to the Community Nursing Services Program Manager at the address at the end of this chapter. The suggestions will be considered during the review process.

Please note that the policies and procedures are dated and numbered. As revisions occur or new policies and procedures are developed, they should be added to the manual. Old policies and procedures no longer in effect should be deleted from this manual.

Revisions to the manual will be distributed to all contractors at least thirty days prior to the effective date of any change, when appropriate. Contractors are required to adhere to the requirements and guidelines set forth in this manual, and are also responsible for incorporating any policy changes into their operations.

If this reference does not answer your questions or concerns, or if you have suggestions for additional information that should be included in the policy manual, please contact:

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